predicting failure are lacking. This study investigated patient characteristics with predictive value for restenosis during the first year after RSFAE.

Design: A prospective cohort study.

Materials and methods: A total of 90 patients post-RSFAE were studied for the occurrence of restenosis "(peak systolic velocity ratio ≥ 2.5)" in the first 12 months postoperatively. At baseline, clinical parameters were recorded. Vessel size was measured on the basis of plaque perimeter in the culprit lesion and lumen diameter on perioperative digital subtraction angiography.

Results: In 57 patients (63%), a restenotic lesion was diagnosed within 12 months following surgery. Patients with longer time interval between start of ischaemic walking complaints and RSFAE revealed a significantly higher incidence of restenosis (hazard ratio (HR) = 1.3 (1.05–1.52) per 4 years). Small plaque perimeter and small superficial femoral artery (SFA) diameter on angiography were significantly associated with restenosis (HR = 0.54 (0.34–0.88) per 10 mm and HR = 0.46 (0.27–0.78) per 1.5 mm, respectively). In multivariate analysis, age, duration of ischaemic walking complaints and lumen diameter were independently associated with increased risk of restenosis after RSFAE.

Conclusions: This study provides evidence that age, vessel size and duration of ischaemic walking complaints before RSFAE are predictive values for restenosis after RSFAE.

Basilic Vein Transposition: What is the Optimal Technique?

Kakkos S.K., Haddad G.K., Weaver M.R., Haddad R.K., Scully M.M. Eur J Vasc Endovasc Surg 2010;39:in press.

Objectives: To compare the outcome of the one-stage basilic vein transposition (BVT) fistula with a modified, two-stage technique.

Design: Retrospective case-controlled study, performed in an academic centre.

Material: A total of 173 candidates for BVT fistula (87 males, mean age 61 years).

Methods: In one-stage BVT, the basilic vein is mobilised through a single incision, placed inside an anterolateral arm tunnel and anastomosed with the brachial artery. In two-stage procedures, the fistula–arterial anastomosis is created first, followed by the second stage, after fistula maturation several weeks later, when the basilic vein is mobilised through two skip incisions, transected near the anastomosis, placed inside an anterolateral arm tunnel and reanastomosed. Morbidity and fistula maturation rate were the main outcome measures.

Results: In one-stage BVT ($n = 76$), the incidence of venous hypertension, wound haematomas and all complications (17%, 13% and 43%, respectively) was significantly higher than in two-stage procedures ($n = 98$) (4%, $p = 0.004$, 3%, $p = 0.012$ and 11%, $p < 0.001$, respectively). Time (68 days) to fistula use was significantly decreased in one-stage BVT than in two-stage procedures (132 days, $p < 0.001$) but failure to mature rate was equivalent (15% vs. 18%, $p = 0.49$).

Conclusions: Our results indicate that the two-stage BVT fistula through two skip-arm incisions is superior to the established one-stage procedure in terms of less morbidity but at the cost of a second operation and longer time to access use. Further research comparing these two techniques is necessary. Until this issue is resolved, an individualised approach is suggested.

Randomised Clinical Trial Comparing Endovenous Laser Ablation with Stripping of the Great Saphenous Vein: Clinical Outcome and Recurrence After 2 Years

Rasmussen L.H., Bjoern L., Lawaetz M., Lawaetz B., Blemings A., Eklöf B. Eur J Vasc Endovasc Surg 2010;39:in press.

Objective: This study aims to compare the outcome 2 years after treatment of varicose veins by endovenous laser ablation (EVLA) or surgery by assessing recurrence, venous clinical severity score (VCSS) and quality of life.

Methods: A total of 121 patients (137 legs) were randomised to either EVLA or saphenofemoral ligation and stripping of the great saphenous vein (GSV). Follow-up included clinical and duplex ultrasound examinations, VCSS and quality of life questionnaires.

Results: A total of 18 (26%) and 25 patients (37%) in the EVLA and surgery group, respectively, developed recurrent varicose veins (not significant (NS) between groups). The source of reflux was not significantly different between the groups. Technical failure occurred in three EVLA and two surgery patients, reflux in the anterior accessory GSV, the groin, thigh and calf perforators was found in six, two, four, and three EVLA patients, and in three, three, nine and six surgery patients. VCSS, Aberdeen Varicose Vein Severity Score and several domains of the Medical Outcomes Study Short Form 36 (SF36) quality of life score improved significantly in both groups.

Conclusions: No significant differences in clinical or ultrasound recurrences were found between EVLA and surgery groups. Our study also shows that similar improvements in clinical severity scores and quality of life were gained in both treatments.

Primary Lymphoedema and Lymphatic Malformation: Are they the Two Sides of the Same Coin?

Lee B.B., Villavicencio J.L. Eur J Vasc Endovasc Surg 2010;39:in press.

Objectives: To clear the confusion regarding the relationship between the 'primary lymphoedema' and (truncular) lymphatic malformation (LM); the latter is one of congenital vascular malformations.

Materials & Methods: A literature review was carried out on the primary lymphoedema either existing as an independent LM lesion or as a component of the Klippel–Trenaunay syndrome.

Results: The review was able to provide a contemporary guide/conclusion on the definition and classification, clinical evaluation and clinical management regarding conservative (physical) therapy, reconstructive surgical therapy and ablative/excisional surgical therapy, for the primary lymphoedema as an LM.

Conclusions: Primary lymphoedema can be considered as 'congenital' since its majority represents a clinical manifestation of the truncular type of LM arising during the later stages of lymphangiogenesis. Such embryological staging information of the LM is critical for proper management of the primary lymphoedema when it exists with other congenital vascular malformations (Klippel–Trenaunay syndrome).

2. Basic non-invasive to minimally invasive tests will provide an adequate diagnosis and lead to the correct multidisciplinary, specifically targeted and sequenced treatment strategy.

3. The mainstay of current management of the primary lymphoedema/truncular LM is complex decongestive therapy; and the reconstructive as well as ablative surgical therapy remain adjunctive therapies at best.